

## DISCLOSURE OF CONFIDENTIAL HIV/AIDS INFORMATION

### SECTION I

I, \_\_\_\_\_, have received the following information concerning  
CARE PROVIDER'S NAME

CHILD'S NAME

☐ HIV/AIDS diagnosis

☐ AIDS symptoms

☐ Names/telephone numbers of treatment providers  
(See Section II)

☐ Activities/comments  
(See Section III)

☐ HIV/AIDS exposure

### SECTION II

PRIMARY MEDICAL PROVIDER	PUBLIC HEALTH/AIDS CASE MANAGER	OTHER
NAME	NAME	NAME
ADDRESS	ADDRESS	ADDRESS
TELEPHONE NUMBER	TELEPHONE NUMBER	TELEPHONE NUMBER

### SECTION III: ACTIVITIES/COMMENTS


### SECTION IV

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose.

I have read and understand the above statement.

CARE PROVIDER'S SIGNATURE	RELATIONSHIP TO CHILD
SOCIAL WORKER'S SIGNATURE	DATE

**Authority to disclose this information:** ☐ RCW 70.24.105 ☐ Parent/guardian permission on file  
☐ Court order ☐ Child (14 or older) permission on file

**CONFIDENTIAL: To be filed only in child's confidential HIV/AIDS file.**